1394731

NATIONAL WESTERN LIFE INSURANCE COMPANY

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

850 East Anderson Lane • Austin, Texas 78752-1602

I. PRIMARY INSURED (Please Print Clearly Using Black Ink)

Linda L. Tromblay | [redacted] | 85 | Washington, USA
Name of Proposed Insured (First, Middle, Last) | Date of Birth (mm/dd/yyyy) | Age | Place of Birth (State and Country)

☐ Male ☒ Female Marital Status ☐ Married ☐ Single ☒ Widowed ☐ Divorced ☐ Tobacco Use ☒ Tobacco Free

[redacted] | [redacted] | [redacted] | [redacted]
Home Address (number and street) | City | State | Zip

[redacted] | [redacted] | [redacted] | Best time and place to call ☐ Home ____ ☐AM ☐PM ☐ Work ____ ☐AM ☐PM
Social Security Number or Tax ID | Drivers License Number and State | Home Phone Number

Citizenship ☒ U.S. Citizen ☐ Foreign National Email ____

If Non US Citizen: Type of Visa ____ Exp date ____ Country of Citizenship ____

Retired | | |
Current Employer | Occupation and Duties | Work Phone Number

| | | |
Employer Address (number and street) | City | State | Zip

II. COVERAGE APPLIED FOR

Plan of Insurance (Name of Product) Lifetime Returns Select **Face Amount** $ 188,205

Riders: ☐ **Accelerated Benefit Rider (Not available in all states)** ☒ **Return of Premium Rider (Not available in all states)**

Riders are only available for single-premium

III. PREMIUMS

Single Premium $ 150,000

Modal Premium: ☐ 5 pay $ ____ to be paid: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly ☐ 10 pay

Method: ☐ Direct Billing ☐ Bank Draft ☐ Other ____

Amount collected with application: $ 150,000

Source of Premium: ☐ Salary ☒ Savings ☐ Investments ☐ 1035 Exchange ☐ Loan (premium financing) ☐ Other (specify) ____

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NB-LIFE
National Western Life

IV. OWNERSHIP INFORMATION (Complete only if Owner is other than the Proposed Insured)

The Tromblay Irrevocable Heritage Trust | [redacted] | [redacted]
Owner / Applicant / Trust Name | Date of Birth (mm/dd/yyyy) | SSN / TIN

Phone Number 937-599-5214 Relationship to Proposed Insured Linda Tromblay

[redacted] | [redacted] | [redacted] | [redacted]
Address (number and street) | City | State | Zip Code

If the owner is a trust, please submit the Trust Information Form.

V. BENEFICIARY INFORMATION (If percentages are not given, the shares will be divided equally)

Primary Beneficiaries

Full Name	SSN	Relationship	% Share
1. The Tromblay Irrevocable Heritage Trust	[redacted]	Trust	100
2.			
3.			

Contingent Beneficiaries

Full Name	SSN	Relationship	% Share
1.			
2.			
3.			

EXHIBIT 1

Proposed Insured Linda Tromblay

VI. OTHER COVERAGE AND REPLACEMENT

1. Does the Proposed Insured have any existing life insurance or annuity policies with this company or any other company? (If yes provide details in #4) ☐ Yes ☒ No
2. Is this policy intended to replace any existing life insurance or annuity with this company or any other? (If yes, please submit appropriate state replacement forms and provide company name and details in #4) ☐ Yes ☒ No
3. Is the Proposed Owner or Proposed Insured considering using funds from an existing policy or contract to pay premiums on the Policy being applied for? (If Yes, complete the appropriate state replacement forms and provide company name and details in #4) ☐ Yes ☒ No

4. Company	Policy Number	Type of Coverage	Amt of Coverage	To be Replaced	1035 Exchange
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

VII. HEIGHT AND WEIGHT

What is your height? 5 ft 2 in What is your weight? 104 Lbs

VIII. MEDICAL HISTORY QUESTIONS (If any question in Section VIII is answered yes, no coverage can be issued.)

1. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☒ No
2. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as bathing, dressing, eating, toileting, transferring or taking medications? ☐ Yes ☒ No
3. Do you use any medical appliance such as oxygen, respirator, or dialysis machine, or have a defibrillator implanted? ☐ Yes ☒ No
4. Have you had or been advised by a member of the medical profession to have, an organ transplant, or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less? ☐ Yes ☒ No
5. Are you currently hospitalized, confined to a bed or nursing facility, residing in an assisted living facility or receiving hospice care? ☐ Yes ☒ No
6. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
   a. Congestive heart failure, cardiomyopathy, cirrhosis of the liver, liver failure, kidney (renal) failure, end stage kidney disease, chronic kidney disease or renal insufficiency? ☐ Yes ☒ No
   b. Alzheimer's disease, dementia, memory loss, mental incapacity, schizophrenia, manic depression, bipolar disorder, brain disease, Lou Gehrig's disease (ALS), Huntington's disease, muscular dystrophy, cystic fibrosis, multiple sclerosis or multiple myeloma? ☐ Yes ☒ No
7. Have you:
   a. Been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for diabetes prior to age 20? ☐ Yes ☒ No
   b. Taken insulin prior to age 40? ☐ Yes ☒ No
   c. Been diagnosed or treated by a member of the medical profession for insulin shock or diabetic coma? ☐ Yes ☒ No
   d. Been hospitalized two or more times for any diabetic complications within the last 2 years? ☐ Yes ☒ No
8. Within the past 3 years have you been diagnosed by a member of the medical profession with leukemia, lymphoma, melanoma or any internal cancer, or received chemotherapy, radiation or had surgery for any cancer (other than basal or squamous cell cancer of the skin)? ☐ Yes ☒ No
9. Been diagnosed by a member of the medical profession as having more than one occurrence or any metastasis of any cancer in your lifetime (excluding basal or squamous cell skin cancer), or an amputation caused by cancer or any other disease, or are you currently being treated by a member of the medical profession for cancer or recurrence of cancer? ☐ Yes ☒ No

Proposed Insured Linda Tromblay

VIII. MEDICAL HISTORY QUESTIONS CONTINUED (If any question in Section VIII is answered yes, no coverage can be issued.)

10. Within the past 2 years have you:
    a. Been diagnosed or treated by a member of the medical profession for, been hospitalized for, taken or been prescribed medication for: Chronic Obstructive Pulmonary or Lung disease (COPD/COLD), emphysema, chronic bronchitis, respiratory failure, chronic hepatitis, liver disease, angina, stroke, transient ischemic attack (TIA), Hodgkin's disease, cerebral palsy, Parkinson's disease, grand mal epilepsy, systemic lupus (SLE) disease, or do you have paralysis of 2 or more extremities? ☐ Yes ☒ No
    b. Been diagnosed or treated by a member of the medical profession for, or been hospitalized for: Heart disease, heart attack, uncontrolled high blood pressure, heart or circulatory surgery, including coronary artery bypass, angioplasty, cardiac or vascular stent placement, pacemaker or pacemaker replacement, heart valve replacement, abdominal aortic aneurysm, or any procedure to improve the circulation to the heart, brain or extremities? ☐ Yes ☒ No
    c. Been confined three or more times to a hospital, nursing facility, convalescent care facility, assisted living facility, or mental care facility? ☐ Yes ☒ No
    d. Been declined for life, health or long term care insurance? ☐ Yes ☒ No
11. Within the past 5 years have you:
    a. Been convicted of a felony or are you currently on parole or on probation? ☐ Yes ☒ No
    b. Been treated, diagnosed, or been advised to have treatment by a medical professional for alcohol abuse or drug abuse, or attempted suicide? ☐ Yes ☒ No
12. Within the last 3 years have you been convicted of operating a vehicle while intoxicated, impaired or under the influence or for reckless driving? ☐ Yes ☒ No

IX. ADDITIONAL INFORMATION

13. Are you taking any medication for any impairment or disease listed in section VIII? ☐ Yes ☒ No
14. In the last 12 months, have you used any tobacco or nicotine products, such as cigarettes, pipes or cigars, snuff, chewing tobacco, or a nicotine delivery device such as a patch, gum or lozenge? ☐ Yes ☒ No
15. Have you applied for life insurance with any other insurance companies in the last 2 years? ☐ Yes ☒ No
16. Do you believe that this life insurance policy is appropriate for your financial situation based on your income, net worth, available funds and retirement considerations? ☒ Yes ☐ No

Details to yes answers in Section IX _____

17. Physician's Name, Address, and Phone Number WPMC Family Care Clinic
Greg. Bellance
[redacted]

Each of the undersigned: Declares that all answers in this application are true and complete to the best of their knowledge and belief, and understands that: (a) all statements and answers in this application will be relied upon by the Company to determine insurability and to issue the policy; (b) no information will be considered given to the Company unless it is stated in the application; (c) the agent does not have the Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions in the application, policy or receipt, as applicable; and (d) a material misrepresentation may void the policy during the contestable period. This policy will take effect when: (1) the application is approved at National Western's Office in Austin, Texas; (2) National Western delivers the policy; (3) the initial premium has been paid; and (4) each of the prior three conditions is satisfied while the proposed insureds are alive and their health and insurability are as described herein.

Proposed Insured: I am not currently taking, or under the influence of, any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I authorize any licensed physician, medical practitioner, hospital, other health care provider, insurance company or MIB, or other organization or person to give any information about me or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for life insurance coverage. The Company may disclose such information to its reinsurers and MIB. National Western or its reinsurers may also release such information to other life or health insurance companies to whom an application for insurance or to whom a claim for benefits is submitted. This authorization also applies to any member of my family proposed for coverage in the application and is valid for 2 years after the date shown below. A photocopy of this form is as valid as the original. I may have a copy of this form upon request.

Each of the undersigned acknowledges receipt of the Notice under the Fair Credit Reporting Act (Consumer Report Notice), MIB Disclosure Notice, and Notice of Information Practices (if applicable).

FRAUD WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

Signed at Bellefontaine, OH — Date 3/25/2020

City and State

Linda L. Trombley

Signature of Proposed Insured (parent if age 17 or less)

Jeffrey J. Trombley, TTEE

Signature of Owner if other than Proposed Insured
(If a Trust, signature of trustee)
(If business or corporation, officer, other than Proposed insured, and Title)

Todd White	B9269	T. White
Agent Name (please print)	License No.	Signature of Agent

Proposed Insured Linda Tromblay

AGENT REPORT

1. How long have you known the Proposed Insured? 3 mo. Are you related? ☐ Yes ☒ No If yes, How? _____
2. Did you personally see the Proposed Insured(s) and complete the application in his and/or her presence? ..... ☒ Yes ☐ No
   If No, please explain: _____
3. Are you aware of any information about any of the Proposed Insured(s) that might affect his/her insurability? ..... ☐ Yes ☒ No
   If Yes, give details: _____
4. Will the policy applied for replace or change any existing life insurance or annuity? ..... ☐ Yes ☒ No
5. Do you have any knowledge or reason to believe:
   a. that the Proposed Insured or Owner is considering assigning or transferring any rights or interest in this policy to an unrelated third party such as a Life Settlement company, Viatical, Investor, trust, bank, lending institution or other third party? ..... ☐ Yes ☒ No
   b. that any of the initial or future premiums will be borrowed, loaned or otherwise financed? ..... ☐ Yes ☒ No
   c. that the Proposed Insured or Owner has taken or been offered any incentive, financial or other, or been offered free insurance as an inducement to purchase this policy? ..... ☐ Yes ☒ No

USA PATRIOT Act Notice

1. The USA PATRIOT Act requires that we establish an Anti-Money Laundering (AML) Compliance Program, and as part of our Program, National Western Life Insurance Company® requires that its agents/brokers/consultants verify the identity of the proposed owner(s) of our contracts and collect documents and/or information sufficient to provide such verification. Please refer to your company-specific AML training materials for more detailed information.
   Owner/Trustee Verification - In order to satisfy such obligations, we require that you review and verify a current driver's license or government-issued photo ID for the proposed Owner/Trustee associated with the contract.
2. Do you certify that you personally met with the proposed Owner/Trustee and reviewed his or her identification document (driver's license or government-issued photo ID) and that to the best of your knowledge, it accurately reflects the identity of the proposed Owner/Trustee? ..... ☒ Yes ☐ No
   If no, please explain _____

I certify that:
a. the insurance being applied for is suitable for the Proposed Insured's needs and financial objectives
b. the consumer notices were delivered to the Proposed Insured or Owner;
c. all questions on the application were asked of each Proposed Insured, and the answers were recorded as given, prior to the application being signed;
d. the temporary insurance agreement was explained fully and (if applicable), the receipt was given.
e. the answers given in this application and Agent's Report are complete and accurate to the best of my knowledge and belief
f. the Proposed Insured and Owner appeared to me to be lucid and to fully understand all of the questions on this application.

Date 3/25/2020 Agent Signature T. White Print Agent Name Todd White

Licensed agent(s) to receive commissions (please print)

Name of Agent	Agent No.	Percent of Commission	Agent Phone #	Agent Email Address
1. Todd White	B9269	100%	[redacted]	[redacted]
2.				
3.				